# 2025 Therapeutic Riding Registration Packet

PARTICIPANT NAME: ____________________________________________________

DOB: ____________ AGE: _______ GENDER: ☐ Male Female ☐ Other: ____________

PRIMARY CONTACT (If under 18 or Guardian): ___________________________________________

PHONE: ______________________________________ EMAIL: ____________________________

MAILING ADDRESS: _______________________________________________________________

If applicable: SECONDARY CONTACT NAME: __________________________________________

PHONE # ____________________________________ EMAIL ______________________________

Preferred contact method for last minute lesson cancellations: ☐ Phone Call ☐ Text Message ☐ Email

***I have read, understand, and agree to TRI's eligibility requirements and policies that are found in the Participant Handbook.***

Signed _______________________________________________Date _________________________

Student (over 18), Parent or Guardian

## *CLASS REGISTRATION INFORMATION FOR 2025 LESSON SEASON*

**REGISTRATION DEADLINES:**

**Spring:** January 27th **Summer 1:** April 14th **Summer 2:** June 16th **Fall:** August 18th

**SESSION YOU'RE REGISTERING FOR:**

***Please note, indicating interest below does not guarantee placement in the session. Registration will be accepted on a first come, first served basis***

☐**Spring (**Feb 17-Apr 19) ☐ **Summer 1 (**May 5-Jun 14) ☐ **Summer 2** (Jul 7-Aug 16) ☐ **Fall** (Sep 8-Nov 22)

**Please Select Your Top 3 Choices for Day You Are Available and Mark Your Preferred Timeslot(s):**

*Each hour indicates the start time of the lesson*

**___ Monday ☐ 2:00pm ☐3:00pm ☐4:00pm ☐5:00pm ☐6:00pm ☐7:00pm ☐8:00pm**

**___ Tuesday ☐ 2:00pm ☐3:00pm ☐4:00pm ☐5:00pm ☐6:00pm ☐7:00pm ☐8:00pm**

**___ Wednesday ☐2:00pm ☐3:00pm ☐4:00pm ☐ 5:00pm ☐6:00pm ☐7:00pm ☐8:00pm**

**___ Thursday ☐10:00am ☐11:00am ☐3:00pm ☐4:00pm ☐5:00pm ☐ 6:00pm ☐ 7:00 pm ☐ 8:00pm**

**___ Saturday ☐9:00am ☐10:00am ☐11:00am**

**TRI PARTICIPANT INFORMATION (Must be completed annually)**

Participant Name________________________________________________________________

Primary Diagnosis ______________________________________________________________

Secondary Diagnosis ____________________________________________________________

DOB ______________ Height _________ Weight___________

Participant is a (mark one) Minor ☐ Adult w/ a Legal Guardian ☐ Independent Adult ☐

Does the Participant Reside somewhere other than with the Parent/Legal Guardian? If yes, list address and phone:

_____________________________________________________________________________

**HEALTH HISTORY TO BECOMPLETED BY PARTICIPANT**

**A PHYSICIAN'S RELEASE MUST BE ON FILE. SEE ADDITIONAL FORMS**

Current Therapies and How Often (PT, OT, Speech, Respiratory) ___________________________

_____________________________________________________________________________

**Please Circle All Applicable to Participant**

| Asthma | Inhaler | EpiPen | Allergies – Type | |
|---|---|---|---|---|
| Independent Ambulation | Walker | Wheelchair | Brace - Type= | Shunt* |
| ALS Interpreter | Service Dog | Visual Assistance | Emotional Support | Catheter* |

**For Participants who use a Wheelchair, Please Complete**

| Wheelchair Only Aids Ambulation Sometimes | Sits Up Unassisted |
|---|---|
| Support Through Trunk Required | Full Support of Head and Neck Required |

(continued on the next page)

PARTICIPANT NAME: ____________________________________

| Yes | Participant with or is Treated For: | Date(s) | Comments |
|---|---|---|---|
| | Down Syndrome | | |
| | Brain Condition i.e. Cerebral Palsy, stroke | | |
| | Spinal Condition i.e. Spina Bifida, Scoliosis, Fusion, Injury | | |
| | Medical Device Implanted (insulin pump, catheter, colostomy) | | |
| | Seizure Disorder | | |
| | Diabetes | | |
| | Joint complications i.e. dysplasia | | |
| | Bleeding or clotting disorders | | |
| | Heart Condition | | |
| | Neurological condition | | |
| | Muscular Disorder | | |
| | Medical Shunt or Feeding Tube | | |
| | Epilepsy | | |
| | Mental Health Crisis | | |
| | Pulmonary condition | | |
| | Violent Outbursts | | |
| | Have altered sensation? (specify) | | |

IN THE PAST 12 MONTHS, HAS THE PARTICIPANT EXPERIENCED ANY OF THE FOLLOWING

| YES | ISSUE | DATE | EXPLANATION |
|---|---|---|---|
| | Loss of consciousness, including seizures | | |
| | Hospitalized for mental health crisis | | |
| | Hospitalized (injury, surgery, etc) | | |
| | Activities been restricted due to medical reasons | | |

I confirm that the information provided is accurate and true as it pertains to the listed participant,

______________________________________________________________________

Name of Person Completing Form Signature Date

**TRI PARTICIPANT CONSENTS & RELEASES**

Participant Name: ___________________________________________DOB ___________

Parent/Guardian/Caregiver: ____________________________________________________________

Address: _________________________________________ City _________________ Zip: ______________
County: _______________________________

Phone: Home ___________________Cell ___________________ Work: ___________________

**Emergency Contact**
If the above cannot be reached, I authorize these people be contacted and participant can be placed in their care.

Name ________________________________ Relationship___________________ Phone _______________

Physician: _______________________________________________ Phone: _____________________________

Medications & Dosage:
_____________________________________________________________________________________________

Please list all known medication allergies: ________________________________________________________

Medical Conditions an Emergency Medical Team needs to know about: ______________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Insurance Carrier: _____________________________________Policy Number: _________________________

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

**In the event of a medical emergency, TRI will provide basic first aid and/or call 911. Personal Health Information will be disclosed as necessary to medical personnel.**

**☐ I Give Consent for Emergency Medical Care as Stated Above**

**☐ I Do NOT Give Consent for Emergency Medical Care. I will not hold TRI responsible my decision to withhold consent. In the event emergency care is required, I wish the following procedures take place:**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Signature: _____________________________________________________Date: ________________

Parent/Guardian/Caregiver: ______________________________________ Date: ________________

**PARTICIPANT NAME: ____________________________________ DOB: _______________**

## PHOTO RELEASE

☐ I DO ☐ I DO NOT consent to and authorize the use and reproduction by TRI of any and all photographs and any audio-visual materials taken of me/my son/my daughter/my ward for promotional material, educational activities, exhibitions and digital displays or for any other use for the benefit of the program. With respect to the foregoing matters, no inducements or promises have been made to secure this signature to this release other than the intention of TRI to use, or cause to be used, such photographs, films, and pictures for the primary purpose of promoting TRI and its work. TRI will strive to keep individuals' identities secure while using photos in newspapers, informational materials, website, Facebook, and other media materials. Likewise, NO photos or images shall be taken of TRI participants, staff or volunteers and used for personal social media (print, broadcast, digital and online) by a participant or their guests without express permission by all parties involved.

## Statement of Understanding, Authorization Release, and Indemnity

_____________________________________________ (Participant's Name) would like to participate at The Therapeutic Riding Institute, Inc. I acknowledge the risks and potential for risks of Equine Assisted Activities and Therapies. However, I feel that the possible benefits to myself/ my son/ my daughter/ my ward are greater than the risk assumed.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators waive and release forever any potential claims for damages against the Therapeutic Riding Institute, Inc. In return for the opportunity to participate in the TRI program, I hereby forever release, acquit and discharge TRI and its officers, directors, trustees, agents, employees, representatives, volunteers, affiliates, successors and assigns (collectively the "Released and Indemnified Parties") from any and all claims, demands and causes of action of any and every kind or nature, including those caused in whole or in part by the negligence of any of the Released and Indemnified Parties, which I may now or in the future have against any or all of the released and Indemnified Parties and that arise in whole or in part as a result of my involvement with TRI. I also understand and agree that TRI assumes no liability for accidents or acts of negligence or gross negligence by anyone, including the Released and Indemnified Parties. I further agree to fully indemnify and defend any of the Released and Indemnified Parties against any and all claims, demands or causes of action of any and every kind or nature (including attorney's fees and other defense costs), including those caused in whole or in part by the negligence of any or all of the Released and Indemnified Parties, which directly or indirectly relate to personal injuries or property damages sustained by me and that arise in whole or in part as a unenforceable, all other provisions shall remain in full force and effect.

**Ohio Statement of Inherent Risks:**

Inherent risk of an "equine activity" means a danger or condition that is an integral part of an equine activity, including, but not limited to, any of the following:

A. The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;

B. The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;

C. Hazards, including, but not limited to, surface or subsurface conditions;

D. Collision with another equine, another animal, a person, or an object;

E. The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

Adult Participant Signature: ___________________________________ Date: _________________

Signature of Parent/Guardian: _________________________________ Date: _________________

I represent to TRI that I am the parent or guardian of the Applicant whose signature appears above. I am authorized to sign this Statement on behalf of the Applicant and my doing so legally binds the Applicant as if he or she were not a minor.

## Participant Information and Goals for 2025 Lesson Season

How did you hear about TRI? ______________________________________________________________________

Is the Participant in School? Yes □ No □ What Grade Level? ________

Special Needs □ Typical Class □

School System ______________________________________________________________________________

Has the participant had prior experience with therapeutic riding? Yes □ No □
If yes, when and where? _________________________________________________________________________
______________________________________________________________________________________________

**For Grant Purposes:**

Select all that apply: □ Caucasian □ Asian □ Hispanic/Latino □ African American □ Native American □ Other

Is the participant one of the following? □ Dependent of Veteran □ Dependent of Active Military Member

**For Lesson Planning Purposes:**

Please list the top three goals you have for you or your rider in the Therapeutic Riding program this year:

1. ____________________________________________________________________________
   ____________________________________________________________________________
2. ____________________________________________________________________________
   ____________________________________________________________________________
3. ____________________________________________________________________________
   ____________________________________________________________________________

**PHYSICIAN RELEASE**

(ALL PARTICIPANTS MUST HAVE THIS FORM COMPLETED ANNUALLY PRIOR TO PARTICIPATING IN EQUINE ASSISTED ACTIVITIES)

*TO PHYSICIAN COMPLETING RELEASE,*

*This person is registering to participate in Equine Assisted Services. Horseback riding has inherent risks; however, some medical conditions are contraindicated due to a variety of factors relating to the activity. Please consider this when completing this form.*

Name: ___________________________________________Date of Birth: _____________Age: ____________

Name of Parent/Guardian: ______________________________________________________________________

Primary Diagnosis: _______________________________________________Date of Onset: ________________

Secondary Diagnosis: ___________________________________________________________________________

Height ___ft ___in Weight _________lbs. Date of Last Tetanus Shot: ___________________

Down Syndrome: Neurological Symptoms of Atlantoaxial Instability: Present______Absent________
Date of AI testing: ____________________________Result: ____________________________________

**Please Mark All That Apply To this Patient**

| Asthma | Inhaler | EpiPen | Allergies - Type | |
|---|---|---|---|---|
| Independent Ambulation | Walker | Wheelchair | Brace - Type= | Catheter Type= |

**For Patients Who Use a Wheelchair, Please Circle**

| Wheelchair Only Aids Ambulation Sometimes | Sits Up Unassisted |
|---|---|
| Support Through Trunk Required | Full Support of Head and Neck Required |

**Please Indicate All Areas Involved**

| | **Description** |
|---|---|
| Cardiovascular | |
| Spinal Condition i.e., Spina Bifida, Scoliosis, Fusion, Injury | |
| Medical Device Implanted (insulin pump, catheter, colostomy) | |
| Diabetes | |
| Musculoskeletal – Body Part | |
| Bleeding or clotting disorders | |
| Neurological condition | |

**Participant Name:** ____________________________________________________________

| Mental Health Crisis | |
|---|---|
| Pulmonary condition | |
| Have altered sensation? (specify) | |

**For Patient's with a History of Seizures**

Date of Last Seizures ______________________Frequency of Seizures ________________________

Type of Seizures ________________________________________________________________

Typical Causes of Seizure Activity _______________________________________________________

________________________________________________________________________________

How does Seizure Present _______________________________________________________________

________________________________________________________________________________

**TO BE COMPLETED BY PHYSICIAN ONLY**

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand The Therapeutic Riding Institute will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to The Therapeutic Riding Institute for ongoing evaluation to determine eligibility for participation.

- ◻ I Agree There Are No Contraindications to Mounted Riding Lessons
- ◻ Mounted Riding Lessons is NOT Recommended, but Unmounted Lessons are Not Limited
- ◻ Restrictions include ________________________________________________________

________________________________________________________________________

Physician name (please print) ______________________________________________________

Physician Signature __________________________________________Date ________________

Medical Practice Name ___________________________________________________

Address ________________________________________________________________

City__________________________State _______Zip __________________

Phone_______________________________Fax _________________________________

***Please Return Completed Form to Participant to:***

***3960 Middle Run Road, Spring Valley, OH 45370***
***Email to: SIngersoll@TRIOhio.org***
***Fax to: 937-862-0010***